Meeting minutes
Prevention Committee
Sacramento, March 20, 2000

I. Introductions:
Sharon Pacyna introduced Dr. Roger Trent of the State Department of Health Services, Injury Control Section.

Members present: Barbara Alberson, John Brown, Fred Claridge, Cindy Hearrell, Nancy Lapolla, Paul Maxwell, Jan Ogar, Michael Osur, Sharon Pacyna, Maureen Phillips, Chris Ryther, Beth Size, David Zenker.

EMSA staff present: Miranda Swanson, Richard Watson, Claudia Zagrean

II Approval of minutes:
Minutes from last meeting were reviewed and approved unanimously.
Meeting Agenda was reviewed and approved without any modifications.

III. Business Items
A. Richard Watson's update on the Vision Process:
- Next year, $30,000.00 more will be distributed to the Vision Project from EMSA funds, and $10,000.00 more from the OTS fund. This will allow for six face to face meetings and four conference calls per Committee.
- The "Big Five"meeting took place on March 3, 2000. Each of the organizations has members sitting on the six Vision committees and reports were made on the progress of the Committees. They established that progress is being made and no legislation will be introduced that would interfere with the Vision Process. Legislation might be introduced that would be mutually beneficial.

B. Jan Ogar's update from the VLT meeting:
- Discussion items at the Vision Leadership Team meeting included progress reports from the other Committees, and a discussion of future action items. Prevention committee members are encouraged to download and review minutes from the EMSA web site, in order to get a better picture of what the other Vision Committees are working on.
- A new draft of the committee handbook developed by the Vision Office is in the process of being finalized.
- Attention was called to the action plan template in the Committee handbook. This template was developed for use by the committees for priority setting. The group process format is meant to aid Committees in getting recommendations out for the larger group
- The issue of how to identify and secure funding for recommended projects was discussed in the VLT meeting. Consensus was reached that as areas that need funding are identified, the issue will be taken to the VLT Committee, which will then look into sources of funding and how needs can be met. The role of the Prevention Committee would be to recommend funding sources.

C. Report by Sharon Pacyna on the Data Subcommittee:

- As an action step for the Data Subcommittee, Sharon Pacyna asked Dr. Roger Trent of the State Department of Health Services to give a presentation on data sets and databases. Dr. Trent's presentation was meant to give the Prevention committee insights on how we might coordinate with DHS.
- Linkage to other data areas are emphasized in the Data Subcommittee.
- Data Subcommittee will be following the NHTSA recommendation that any EMSA established prevention programs should be coordinated with other departments.
- Goal is to interface with System Review and Data Committee to ensure that prevention elements become incorporated into the uniform data set that the Committee is working on.
- The Data Subcommittee is looking at data collection systems that might be useful for prevention.

D. Presentation by Roger Trent:

- Roger Trent represents the EPIC (Epidemiology and Prevention for Injury Control) branch of DHS. EPIC does surveillance of data, epidemiology and focus studies. Data available from other sources in used for the purposes of injury surveillance and injury control.
- There is not a data set collected for the purposes of injury control. Data is collected for other purposes, but it is used by EPIC for description of injury patterns.
- Handouts summarizing data sets and injury death data were distributed.
- Roger discussed the following available data sets:

<u>Mortality Data</u>:

- There are two kinds of death data files: single cause of death and multiple causes of death. Single cause of death is used more often and it specifies the underlying cause of death (example: head injury, not car accident). Multiple causes of death data lists every single cause of death.
- If someone dies due to an injury, it becomes a coroner's case, involving an investigation and often an autopsy. A death certificate is generated by the coroner's office which is filed with the county and later sent to the Department of Health Services, Vital Statistics Unit. Here the cause of death is coded and a single cause of death file is created. A cause of death tape is created, information from the death certificate is sent to the National Center of Health Statistics where the causes of death are sorted through to make sure they make sense.
- Underlying cause of death is coded as an E-code, which is valuable for injury surveillance since it shows what event killed the person. For more specific information regarding the types of injury, the multiple cause of death file can be used.
- E-coding is part of the International System for Classification of Diseases. These are virtually universal codes.
- All injury death certificates are E-coded. Medical causes of death are not E-coded since only injuries have an external cause of death; some gray areas exist (e.g., long term exposure to a harmful chemical).
- Death certificate reports the deceased's level of education, which is indicative of the

socio-economic status of the person. This record is not found on any other injury file.

- Unique identifiers on death certificates are: social security number and date and place of death. These are things that make for unique matching. If the social security number is missing, a probabilistic matching can be made using the name.
- Anybody can have access to mortality data, which is available on CD-ROM. for a small fee. County specific data is also listed.

Hospital Discharge Data:

- Admission as an in-patient to a hospital generates a record that is collected by OSHPD (Office of Statewide Health Planning and Development).
- Data includes a social security number (no name), it includes the dates of admission and discharge and several ICD-9 codes: primary code if only one injury occurred, several ICD-9 codes for multiple injuries and all of the diagnosis E-codes (up to 25 diagnoses).
- Recent data shows an overall decline in death by injury. Falls among the elderly exhibit an upward trend. Poison injuries displayed a downward trend.
- Collecting local data following a uniform data set will allow for comparability among the counties.

OSHPD Data:

- OSHPD's focus in collecting data is medical, including cost, number of days and who's paying for treatment.
- OSHPD's data used to be two years old, now it is one year old. Each hospital has a different relationship with OSHPD and the data is confidential.
- There are four different sets of data owned by OSHPD: raw data, which has all of the patient's information on it. The public sets, A or B contain generalized info about the patient. A fourth set gives age information by year. The zip codes are listed as 3 digits.

Emergency room reporting data will become available 2002:

- This newly created database will collect data about people treated in the emergency room.
- Emergency room data will be treated the same as hospital discharge data.
- Death data is difficult to work with, because it is hard to characterize trends (except in large populations). Emergency room would generate large sets of data.
- Transition in encoding system, from ICD-9 to ICD 10 (International Classification of Diseases) will cause discontinuities in trend analysis for about 5 years.

Other types of data available:

- NEISS (National Electronic Injury Surveillance Systems) collects data on product related injuries.

EPIC's future goals:

- Focus is to put more data on the web. A remote goal is to develop a system of putting mortality data sets into a custom data table, classified by age.
- More work to be done on violent injury data and traffic related injuries; develop a new surveillance for fire arms injuries (not homicides) involving youths under 19, investigated by the police (question regarding access to guns).

E. Group discussion on data sets:

- There is a problem with retrospective use of data for injury control since some data points are not being collected. Databases are owned by different people who are interested in

different aspects of data. For example, first responders are interested in patterns of care, others are interested in medical economics, some are medical legal aspects of data.

- Each database is a piece of the picture. They cannot be homogenized into a big database. Linking data sets is problematic.
- Counties are dissimilar when it comes to injuries; they should share mechanism but be allowed to decide what injury they want to focus on (depending on what is seems to be a problem in that county).
- New data sets focusing on prevention are needed. EMS data should be compared with other sets of data being collected. One could start by looking at epidemiological data and identifying missing areas.
- Observation is important in prevention, collecting information about the specific circumstances surrounding an injury would generate data that is not being collected currently. This type of data is difficult to obtain since EMS doesn't have it and paramedics are not collecting it.
- Smaller surveillance studies might be useful if projects could be funded as pilot studies. Survey tools should be developed to go to the EMS agency and the EMS providers.
- It was suggested that the committee pick a few areas to concentrate on. Also suggested was the development of a five year plan for prevention using the available systems.
- Interface with Data Committee is important in determining what kind of data collection systems are available. Prevention Committee will identify prevention elements to become part of the standard data set.
- Having the state trauma registry guidelines would be useful for data collection.
- Developing test sites for individual systems is desirable.

Summary: The direction of the committee is to identify several types of injuries and look at some common elements that could be collected in order to determine what would be an ideal data set.

F. Nancy Lapolla's report on the Outreach Subcommittee & group discussion:

- Minutes from the Outreach Subcommittee's first conference call were handed out.
- The purpose of the subcommittee is to develop an implementation plan for outreach and program registry.
- The terms "outreach" and "program registry"were defined; group confirmed.
- The specific Outreach objectives (listed on the conference call minutes) were presented to the group for additional review and discussion. The following key points were made:
- It was suggested that the Outreach Subcommittee start listing existing prevention programs within local EMS agencies in California, and then identify gaps based on findings.
- Regarding objective #1(pg. 41), it was emphasized that the committee should become a resource through the registry. Outreach efforts should be expanded to include the prevention activities in the state strategic plan and local EMS agencies.
- Prevention programs should be identified and shared through a registry online; they should also be sorted so that they are useful and accessible.
- Registry would be updated by local EMS Agencies submitting information on the web, sharing prevention programs and projects

- Links to other web sites should be provided as part of the registry.
- Objective # 4, increased focus on injury prevention in the EMS workplace needs further clarification. A lot of places do not have the right training programs to promote health and safety in the workplace, other places do have the equipment but don't do anything about prevention. Awareness isn't there on how to be compliant with OSHA's standards.
- Separate criteria format should be developed for work place registry and a sort should be done on the type of information that might be useful.
- Evaluation of prevention programs are important in proving that the chosen method works.
- A manual of local EMSA programs funded by EMSA grants exists and could be used as a resource.
- EMS Prevention programs should be in alignment with other existing prevention programs in the community.
- Collaboration involving key partners is important in prevention. EMS could serve as a bridge to the right community, focusing on specific types of injuries.
- Involvement of EMS in prevention means providing the tools to become involved in that community, rather then the programs.

G. Review of Prevention Objectives:

(For a listing of the objectives, please refer to the action plan template handed out at the meeting, or your Vision blue book)

Objective # 1: Outreach has a piece; recommended that it becomes a priority with EMSA

Objective # 2: Group objective, needs to be re-framed. Prevention needs to coordinate with Funding Committee regarding this objective. Limited funding is a problem. EMSA to identify funding sources through a resource development person, someone to write the grant, perhaps a health educator.

Objective # 3: Assigned to the Data Subcommittee. One suggested approach was to narrow down this objective by looking at what data sets are already available and wouldn't need to be collected.

Objective # 4: Assigned to the Outreach Subcommittee. Outreach using the web site would be a good direction. Collaborating with the Education Committee is needed on this objective.

Objective #5: To be worked on by the whole group.

Objective #6: Assigned to the Data Subcommittee.

Objective #7: Assigned to the Public Education Subcommittee. Specific areas should be targeted. In providing continuing education, find out what would be the most useful information that should be disseminated.

NHTSA Objective # 58: To be discussed with Lois Williams of EMSA.

NHTSA Objective #59: To be accomplished by the Registry; Outreach Subcommittee is focusing on this.

NHTSA Objective #60: To be worked on by the whole group. Also covered in other objectives involving education. Focus should be multi-year funding for prevention.

NHTSA Objectives # 61, 62: Assigned to EMSA.

IV. Future steps:

- Next two meetings will be used to set priorities, as this step has to be completed by the end of June, 2000.
- Future goal will be to get a clear definition of each data points that need to be collected and some examples, build a dictionary of all the technical pieces and determine how it should be reported.
- Rough out the action steps with the help of other committee chairs.
- Objectives will be looked at in more detail at the next meeting.
- Goals are classified as follows: short term (6 months) intermediate(1 year), long term (3 years). Product will be put together using the group process format, as outlined in the Committee handbook.
- Barbara to bring a guest speaker from DHS, at a future meeting. She will talk about asthma prevention and share in the process of what could be accomplished with a data set.
- Vision Conference to take place Fall 2000, November or early December. More information will became available later.
- The June meeting to take place June 26, 2000 from 2pm to 7pm in San Francisco, in conjunction with the EMSAC meeting.
- **Next Prevention Committee meeting will take place May 22, 2000 at Scripps Mercy Hospital, Education Center, Room 5A, San Diego, CA** . Time will be set aside for Subcommittee work. Public Education Subcommittee to have a conference call prior to the meeting.